Meeting Minutes
Health Information Technology Council Meeting

April 08, 2013
3:30 – 5 p.m.

One Ashburton Place, 11th floor Matta Conference Room
Boston, MA

Meeting Attendees:

Council Members:

Name	Seat	Organization	Attended
John Polanowicz	Secretary of Health and Human Services or Designee (Chair)	*Secretary of the Executive Office of Health and Human Services*	Yes
Manu Tandon	Secretary of Health and Human Services or Designee (Chair)	*Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
John Letchford (Designee for Glen Shor)	Secretary of Administration and Finance or Designee	*Chief Information Officer, Commonwealth of Massachusetts*	Yes
David Seltz	Executive Director of the Health Policy Commission or Designee	*Executive Director of Health Policy Commission*	No
Aron Boros	Executive Director of the Center for Health Information Analysis (CHIA)	*Executive Director of Massachusetts Center for Health Information and Analysis*	No
Laurance Stuntz	Director of the Massachusetts e-Health Institute	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	Secretary of Housing and Economic Development or a Designee	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	No
Julian Harris, MD	Director of the Office of Medicaid or Designee	*Director of Office of Medicaid*	Yes
Meg Aranow	Expert in Health Information Technology	*Senior Research Director, The Advisory Board Company*	No
Deborah Adair	Expert in Health Information Privacy and Security	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	From an Academic Medical Center	*Chief Information officer, Beth Israel Deaconess Medical Center*	Yes
Normand Deschene	From a Community Hospital	*President and Chief Executive Officer , Lowell General Hospital*	Yes
Jay Breines	From a Community Health Center	*Executive Director, Holyoke Health Center*	Yes
Robert Driscoll	From a Long Term Care Facility	*Chief Operations Officer, Salter Healthcare*	Yes
Michael Lee, MD	From a Large Physician Group Practice	*Director of clinical Informatics, Atrius Health*	Yes
Margie Sipe, RN	Registered Nurse	*Nursing Performance Improvement Innovator, Lahey Clinic*	Yes
Steven Fox	Representative of health insurance carriers	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	No

Name	Seat	Organization	Attended
Larry Garber, MD	Experience or Expertise in Health Information Technology	*Medical Director of Informatics, Reliant Medical Group*	Yes
Karen Bell, MD	Experience or Expertise in Health Information Technology	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	Expert in Law and Health Policy	*Professor of Law and Health Sciences, Northeastern School of Law, Bouvé college of Health Sciences*	No
Daniel Mumbauer	From a Behavioral Health, Substance Abuse Disorder or Mental Health Services Organization	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	No

Others:

Name	Organization
Adrian Gropper	*Mass Medical Security Patient Privacy Rights*
David Smith	*MHN*
Eric Hillman	*EOHHS*
Jim Albert	*Jordan Hospital*
Joann Buckland	*EOHHS – Legal*
Joshua Allen Dicker MD.	*EOHHS*
Kim Haddad	*ANF*
Lisa Fenichel	*E-Health consumer Advocate*
Mark Belanger	*MAeHC*
Mickey Tripathi	*MAeHC*
Pam Goldberg	*Mass Tech Collaborative*
Robert McDevitt	*EOHHS*
Sean Kennedy	*MeHI*

Meeting Minutes:

Meeting called to order – minutes approved

The meeting was called to order by Secretary Polanowicz at 3:45 PM.

Council reviewed minutes of the March 13, 2013 HIT Council minutes. The minutes were approved as submitted.

Discussion Item 1: Advisory Group Update & Discussion (slides 4-5) presented by MAeHC CEO Micky Tripathi

See slides 4-5 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

(Slide 4) Each of the 4 Advisory Groups (AG) has met twice this year – in February and March. First, we would like to share a synthesis of what was discussed and the views emerging from these meetings. These are not full consensus recommendations but more expert reactions. We posed a set of questions to each AG, gathered the expert input, and then synthesized it for all of you (HIT Council) and to inform the EOHHS process at large. Second, we want to talk more specifically about the Legal & Policy AG and would like to get input from all of you on the agenda that they have set for moving forward. They have begun to think through the transition from a phase 1 "push" model to a phase 2 "query-retrieve" model and the issues that emerge from there. We inventoried the issues that are there and set priorities – we would love from you (HIT Council) your perspective on this; Did we capture the right set of issues?; Are there other issues out there that we should capture?; Is it the right order in your opinion?; Is there any guidance you would like to provide to the Advisory Group as they start to dive deep down into each topic over the next calendar year?

Advisory Group updates. In February each AG reviewed the proposed phase 2 roadmap and got general feedback from AG members. In March each AG split off into its area of expertise - Providers addressed provider-specific issues - Consumers addressed consumer-specific issues:

- The Consumer AG began its discussion of patient facing services and addressed the question "what would we need to do to have patients be network participants."
- The Legal & Policy AG inventoried and prioritized key issues to work through this year.
- The Provider AG focused on adoption of HIE services and enablers for this adoption. What are they seeing in the market and what issues are emerging and what are enablers.
- The Technology AG dove into a whole variety of technical issues for phase 2 services

The following points summarize the general themes for each 90 minute meeting – detailed slides are also available *(slides 6-9)* for reference.

- The Consumer AG believes approaches to patient engagement and activation should be accelerated. We have a starting point here – being able to go to HIX (Health Insurance Exchange) or Medicaid to get a direct address so they can have things sent to them on the HIway. Those kinds of things are great but do not go far enough or fast enough.
- The Provider AG discussed alignment between the Mass HIway and other HIE activities underway in the state, such as Safehealth in Worcester, the Pioneer Valley Information Exchange, or Emerson. There are HIE efforts underway in every part of the state and they are starting to bump up against the HIway. For example, let's say I am working at a practice out in Springfield and there are HIE services available to me – the HIway is also approaching me – how do I think about that problem – I do not want to have 2 interfaces but also don't want to be left out. We are getting the sense that providers are going to connect to the Mass HIway but they

still don't know the steps they have to take to implement and how does that line up with what is really important to the provider locally as well (e.g., With what my hospital is offering me). I may be part of an ACO and have more of an imperative to figure out how this is going to happen locally, recognizing that the HIway is not going to solve all my problems but can help me solve some of them.

- The Technology AG acknowledges that Mass HIway needs to remain open and flexible to standards as they evolve and that the market is developing quickly and in some ways that are predictable and some ways that are not. For example, CommonWell, a coalition of EHR vendors that have assembled to advance interoperability in the face of the Epic and eClinicalWorks proprietary networks. How do we think about that and how does it fit in. There are not yet nationally defined standards for query so we need to remain flexible to what happens nationally, with respect to the industry and meaningful use, which may drive some of those. HIT standards Committee helps define those as well – with John Halamka as chair we may have some role in defining standards but we need to acknowledge that the industry is very heterogeneous and, as we saw in phase 1, we need to stay open and flexible to what is out there and look for convergence.
- The Technology AG also noted that the Record Location function needs to be highly constrained in order to protect patient privacy. For example, a provider searching for a patient should not be given multiple returns to choose from but instead should only be able to view a patient for which there is a direct hit for entered search criteria. Record queries should not go through the Mass HIway but should be peer-to-peer transactions that are vetted by the HIway RLS and expressed patient consent parameters. There is a longer term goal to allow patients to manage their own consent preferences as network participants. Business and technology does not currently support this so in early stages consent will be collected at provider level and communicated but, as quickly and aggressively as we can start to put in place the processes and technology to allow patient control.
- We just summarized about 10 hours of conversation in about 4 minutes and would love any comments or questions on this, especially members of the Advisory Groups that have anything more to mention on this.
    - Comment (John Halamka): Especially around the privacy and security issues we need to tread delicately. John provided an example of a patient that has a record at McLean Hospital and who has not given consent to share this information. John noted that the HIway will never disclose this information. However, as the steward of the information associating the patient with McLean, the state has to wrestle with a whole set of issues we haven't had before since the state is moving from a position of facilitating exchange of information to one where the state is an actual steward of that information.
    - Comment (Micky Tripathi): Micky provided example of how patients could be more aggressively engaged by allowing them access to state immunization information. 4-5 states currently allow patients to do this. This raises complex questions of whether DPH can actually do this, how much it will cost, and whether there are better ways to do this such as through providers.
    - Comment (Jay Breines): We could put this service (immunization checking) within the school registration process. This would reduce effort spent and cost to primary care providers for tracking down and sending records.
    - Comment (Laurance Stuntz): Louisiana is doing this with their school nurses and tying this in with patient education and consent.
    - Comment (Jay Breines): We could have community health centers and schools could share information regarding absenteeism.

- Comment (Larry Garber): Consenting needs to be easy and simple to do. One option is a "General Opt In" with exceptions.
- Comment (John Halamka): Noted that yesterday ONC gave out 2 grants, one to the New York eHealth Collaborative and one to DIRECT Trust, to have them start looking at how to create trust fabrics, governance, rules of the road that govern an information exchange. We always want to follow standards and remain sensitive to what are becoming national trends or national standards. For example, we may put up a record locator service and then 5 years from now, take it down if there is a national infrastructure in place – and hopefully following standards will make that an easy transition to make.
- Question (Karen Bell): Referred to the consumer Advisory Group summary (slide 6) There is a need for statewide consumer education. To do so we need to deal with consent. Is the Consumer AG working on this as well and are we getting a lot of feedback from that work group?
  - Answer (Micky Tripathi): We will be. As part of that same point, Consumers would like to see large scale consumer engagement. This is complex – even within the group there is a wide range of interpretation of the services. The plan is to revisit the phase 2 patient facing services again in the next meeting and then to start to think about how to communicate it, not just consent, but the whole service offering.
- Question (Laurance Stuntz): Are AGs only addressing phase 2 or phase 1 as well? On phase 1 we could also use some help.
  - Answer (Micky Tripathi): Policy planning is focused specifically on phase 2. Updates to the AGs are general. Last year the Work Group decided not to pursue a big splash announcement related to Phase 1. The idea was that it is still largely back office, its push; it really mimics what happens today with fax. But here we are now with phase 2 and the sense is that with other critical things happening – at some point there needs to be broad communication and we need to figure out exactly how that would work and what to communicate.
- Comment (Deborah Adair): When patient-directed services start to happen, we need to inform providers as well. We should also double the amount of time for consent planning.
- Comment (Micky Tripathi): We have been careful over the last year and a half not to create a false dichotomy - which we are either focusing on the patient or focusing on the provider. We need to focus on the providers first in order to bring benefit to both.

(Slide 5) The Legal & Policy AG inventoried and prioritized a category of issues to address this year. Question to the HIT Council: Is this the right set of issues, the right prioritization, and is there any guidance for the AG in addressing these. (See slide for each issue):

- *Legal issues with statewide master patient index and record locator service*: Fundamental question - are there consent issues with populating a statewide master person index (MPI) and record locator service (RLS)? Can patients access the RLS to see what is there about them? There are multiple legal, privacy, security, and responsibility questions to resolve.
- *HISP to HISP trust*: A Health Information Services Provider, or HISP, is a network, defined by a set of rules and policies that set up a trust fabric, and backed up by a technical solution (e.g., A security certificate) that enables someone to participate while excluding others from participating. We have created a statewide HISP with a process that allows any TPO (treatment, payment, operations under HIPAA definition) participant in Massachusetts to be a part of it and

have devised a technical solution to allow the providers to connect. That works out fine if you imagine the World is going to be very well behaved. But when you hit the market there are several different models emerging which are not technically difficult to solve but which raise some very challenging business and policy questions. For example:

- Cerner has its own network of Cerner customers. Does Mass HIway need to now join the Cerner Network? By trusting the Cerner Network does a Massachusetts provider may need to trust a hospital in Iowa. This may be fine for push but how about patient search or a query?
- State of New Hampshire may also need to connect.
- Perhaps the Pioneer Valley Information Exchange will determine that it should be a HISP on behalf of its members. How will PVIX then connect with the Mass HIway?
- Comment (John Halamka): There are 2 problems here. The first is authenticating the identity of the individual sending or querying. This issue is easier and could be solved with Direct trust or another similar solution. The second is trusting the individual once we know his/her identity. We need to solve for users that are authenticated but who are bad actors. John raised example of "Joe's Endoscopy Shack" as a known bad actor.
- Comment (Micky Tripathi): Micky raised the Epic to Epic example which could include Partners, Leahy, BMC, Atrius, etc…

- *Consent for query (targeted and untargeted)*: Refers to just consent for query. Using nomenclature from federal privacy & security tiger team, "Targeted query" is when someone knows that a patient's information is at a specific institution (e.g., Lowell General Hospital) and asks for it. "Untargeted query" is when someone broadcasts to the network for information.
- *Patient participation in HIway services*: Giving a patient access to the RLS is one example. Using Microsoft HealthVault as an example of a personal health record that could be connected to the Mass HIway, there are some real business questions raised (e.g., Validating identity and the fact that HealthVault account is mine, who provides password support). Everyone agrees that they want this to happen but the questions are around how you enable it to happen. The plan is to leverage the health insurance exchange (HIX) and Medicaid enrollment business processes for validation of patient identities. This service could also be used to enable patients to access their immunization information.
  - Comment (John Polanowicz, Normand Deschene, Larry Garber, Michael Lee and John Halamka): Discussion of rules for providers and staff access to their own records.
- *Applicability of Chapter 224 HIE provisions*: All providers are to be connected to the Mass HIway by 2017. The law says they have to do this and now they need to know the details. What if a provider is part of PVIX (a Regional HIE), do they also have to be connected to the HIway – directly or indirectly? – for phase 1 or both phase 1 and phase 2? There are a lot of points to figure out and a law that says they have to do it so providers are going to need to understand what that means.
- *Statutorily protected HIV test result and genetic test result data & statutorily protected substance abuse treatment data*: These are vexing issues. In phase 1 we are imitating processes that happen today via fax so there are no real issues there, but the minute you start to add query we start to open questions of how are we interpreting the laws (across organizations). Interpretations of the statutes governing treatment of protected information are all a little different.
  - Comment (John Halamka & Larry Garber): Discussion of how consent for HIV test result information may be needed upon disclosure and again upon view that information.
  - Comment (John Halamka): Beth Israel Deaconess operates no substance abuse treatment programs – Does CFR 42 part 2 apply to us or not? For example, when my

medication list contains OxyContin can I send it to another provider? Those are the 2 very tricky issues and I think what we need is legislative change because the HIV community believes the current law as written is un-implementable because a patient consents to release HIV data yet the doctor it is sent to can't view it unless they get consent again every time they are seen.

- Comment (Micky Tripathi): There is another murky part of the law regarding whether it is the test result or the condition. Many organizations have interpreted the law as being protection of the test result only – the antibody/antigen test. The information re. the HIV condition can be released in part because the organization does not know exactly how it got the information and it could have been self-reported.
- Comment (Larry Garber): Also a question of whether the information re. ordering of the HIV test is protected.
- Comment (Karen Bell): There is also the question of having the patient choose what information it is that they would like to have released. The last 2 bullets bring up questions of segmentation (parsing out a medical record so that some information may be withheld) and consent.
- Comment (John Halamka): Related to data segmentation, the new HIPAA Omnibus rule requires that information not go to insurer for self-pay customers. John provided an example illustrating how hard this will be in a series of information flows, some of which are insurer paid and one of which a patient paid cash for.
- Comment (Michael Lee): The crazy part is that many providers already know that a patient has HIV – but they can't ask the question of other providers.
- Question (John Letchford): This is a scary amount of stuff that has to be resolved. The Question on my mind is what is the framework for us – is the work group trying to bundle these issues into releases – defining actors, users, use cases – so that we can resolve these problems then deploy that out. What is the methodology because it looks like we have a hundred years of work here?
    - Answer (Micky Tripathi): We are not starting from scratch. We can build upon the work of the last Legal & Policy Work Group as well as the ad hoc work group that preceded it. On many of these specific issues we have some experience with providers and the state as well as collaborative organizations like mine (Massachusetts eHealth Collaborative), MHDC (Massachusetts Health Data Consortium). The idea with the Advisory Groups, and with the transition from Work Groups to Advisory Groups, is to alleviate the burden of them having to do a whole bunch of staff work. It will be up to us, as staff and with Council guidance, to tee up the framework for working through each issue. This is an agenda for the entire year and will serve as a forcing function to help us resolve the key questions –recognizing that this will be an iterative process.
- Question (Karen Bell): There are a lot of issues with Payers having access to information. Can we add "Payer Access to data" to the issues list as well?
    - Answer (Micky Tripathi): Yes
- Comment (Larry Garber): Would like to add 2 more items; "Standardized consent language" and "Global Opt in."
- Comment (Deborah Adair): Agree
- Comment (Micky Tripathi): Relayed experience from the pilot projects where they wanted to enable this model. The guidance from the Mass Medical Society legal counsel was that in effect, every provider organization is "deputizing" every other provider

organization on the network for performing a key function, which is the disclosure of information.
- Comment (Larry Garber): It is what we do with Epic
- Comment (Michael Lee): Explained how the Epic to Epic query process works where they print out each other's consent forms and have patient sign.
- Comment (Larry Garber): Would like to add "Data Segmentation."
- Comment from public (Adrian Gropper): Mr. Gropper introduced himself and that his organization has been working on that list of issues for over 3 years on a number of fronts and would love to participate. He sees Massachusetts as being far ahead on this and has been encouraged by the White House to help accelerate this process.

Discussion Item 2: MeHI EHR Records Plan Preview (slides 11-17) presented by MeHI Executive Director Laurance Stuntz

See slides 12-17 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

(Slide 12) Will go through the update quickly but do want HIT Council members to provide input. As the federal grants end next February, MeHI will start to transition into HIT adoption support. Reviewed timelines on slide 12. Regarding requirement for all providers to connect to HIway a definition could be; we can find you in the directory and we can send something to you. Whether the provider gets it directly or through say the Pioneer Valley Information Exchange doesn't really matter as long as any participant on the HIway can send you information and potentially query. A lot to be worked out there and in addition, meaningful use stage 2 is coming later this year. (See slide)

(Slide 13) Explained 5 key things MeHI is charged with from Chapter 224. (see slide)

(Slide 14) In general, goal is to get the data digital, get it moving, and then support innovation that is enabled. (See slide)

(Slide 15) Explanation of core strategies for leveraging extension center and HIE staff to share resources and infrastructure. (See slide)

(Slide 16) There are roughly 27,000 physicians in Massachusetts that will need to be meaningful use certified by 2015 as a condition of Massachusetts licensure. Think we are far down that path – have identified roughly 3,000 providers will need additional help over next 2 years. Will need to spend time and resources assisting providers in ancillary services, long term care, behavioral health, and home health care. In particular, many issues with data sharing with Behavioral Health providers. Home health is an area where there is already a great deal of technology since it has been needed to support a mobile workforce. (See slide)

(Slide 17) Review of Q2 focus areas. Expect there will be a lot of overlap with the Consumer Advisory Group on communication – need to find a way to be effective here but not spend a lot of money. (see slide)

Discussion Item 3: Mass HIway Update (slides 19-23) presented by MeHI HIE Director Sean Kennedy

See slides 19-23 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

(Slide 19) Review of integrated process with goal of connecting both small providers and very large organizations. Explained segments, channels, sales funnel, and adoption feedback loop. (See slide)

(Slide 20) Explained readiness-based segmentation. Explained how marketing and acquisitions strategy is different for each segmentation and accountability for each segment has been divided among Last Mile and EOHHS Operations with triage and handoffs to EOHHS for implementation and support. (See slide)

(Slide 21) Explained HIway Implementation grants and participation in webinars – 93 total attendees. Broad distribution across the state (see map). We have gotten tremendous feedback and many calls and should see a lot of good grants come through. Should have notifications of award coming May 3. (See slide)

(Slide 22) Explanation of sales cycle and sales force metrics. Currently have 92 opportunities representing over 400 organizations and projecting revenue of over $800,000. This is encouraging. Showed how participation agreement signing is to be tracked and organizations handed off for implementation. (See slide)

- Question (John Letchford): What is the process, once people are live, for getting the feedback to others regarding frustrations and challenges and how things are being addressed? How can information from the users feed into the work groups?
    - Answer (Sean Kennedy): We are feeding information to the Advisory Groups already and have sent a number of the questions we have heard. Plan is to develop "cases" that we can share with EOHHS Operations. Frankly, there are several issues where we don't have answers yet. We've got one person live now - once we have more we will be able to get this going
- Comment (Laurance Stuntz): That's the intent of the feedback loop – understanding how people are using this, what are they using it for, whom are they trading information with.
- Comment (John Letchford): The feedback loop can help us prioritize what is important to the actual users.
- Comment (John Halamka): Orion has been a very good organization to deal with and very flexible. Right now we are sending roughly 50,000 transactions per week. John mentioned an issue that they are now resolving regarding required changes to the Orion LAND appliance in order to maintain BID's network security. Orion has agreed to make the changes tonight. There have been bumps along the way but we're getting there.

(Slide 23) Quick review of adoption. (See slide)

Discussion Item 3 continued: Mass HIway Update (slides 24-26) presented by EOHHS CIO Manu Tandon

See slides 24-26 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

(Slide 24) Tufts MC and Network Health should go live next week – they are in final stages of their testing – they sent 25,000 transactions in test. This sets us up well for the next wave that is coming – BIDMC, Holyoke, Atrius – which is substantial – I expect that to go live next month. Toward the end of this month we'll be rolling out several nodes for public health. (See slide)

(Slide 25) Transaction exchange is up from 17 to a little less than 6,000 – all test transactions. We are in the processes of getting a test environment up. The LAND device is being used like it had never been imagined to be used – Orion is working as fast as they can to address our issues and are enthused about the way Massachusetts has taken on the LAND device. They are also working on ramping up their resources. (See slide)

(Slide 26) Switching to timeline for phase 2. Dates have not changed except for CMS approval of APD – this is in final signature process so we should be getting that this week which would release the funding to do the rest of the work. We are in final stages of negotiating our contract change order in order to get the functionality developed. We have these 4 nodes that should go live (Immunization Registry, Reportable Lab Results, Syndromic Surveillance, Children's Behavioral Health Initiative) at end of April and in May – for Public Health and CBHI program – and these dates haven't changed – we are still targeting May – October to update all of the public health nodes. We have this year to get up and running. (See slide)

Discussion Item 4: Wrap up and next steps (slides 28-29) presented by EOHHS CIO Manu Tandon

See slides 28-29 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

The next HIT Council meeting is May 6th.
The agenda for that meeting will be the same as today with discussion up front and updates at end if everyone agrees that this format is working. May also have users share their experiences on how implementation is going at beginning of the meeting. We will keep focusing on development of phase 2.

The HIT Council meeting was adjourned at 5:00p.